

HEALTH CARE FOR HOMELESS NATIVE AMERICANS

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SUMMARY

Introduction/Overview

Native Americans experience among the most severe health disparities of any group in the United States, and they are disproportionately represented among numerous high-needs groups, including the homeless. This report describes some of the key factors contributing to this inequity, the effects of which are expected to continue worsening, and then describes in general terms how health services are delivered to Native Americans and barriers preventing adequate access to those services. Finally, interviews with individuals providing health care to Native Americans who are homeless are used to offer some tentative solutions for overcoming access barriers in the short-term.

Factors Contributing to Homelessness and Health Disparities

History: The history Native Americans have experienced in the United States, resulting in dispossession of land, family, and cultural ties, must be understood as the foundation upon which contemporary realities have been built.

Demographic Characteristics: There are 2.5 million Native Americans in the United States (.9% of the total population), and this number is expected to grow to 3.1 million by 2020. This rapidly growing, ethnically diverse population has severe economic disadvantages when compared with the U.S. population. Low income, unemployment and limited education create tenuous financial situations which can lead to homelessness and health problems as well as limited access to quality health care. Native Americans are also a young population on the whole, which, among other things, means a smaller cohort on which the very young and very old can be economically dependent. They are also more apt than other populations to reside in unhealthy environments with unsafe water supplies, inadequate disposal facilities, and in close proximity to toxic waste sites.

Urbanization: In the past few decades, the number of Native Americans living on reservations or trust lands has decreased significantly, such that today well over half (61%) of the Native population live in urban areas.

Housing Problems: In urban areas, Native Americans experience discrimination when trying to compete for an increasingly scarce supply of affordable housing. On reservations, the housing shortage is acute – individuals linger on waiting lists an average of 41 months – twice the national average – for low income rental units. The condition of housing on the reservations in general is dismal; 40% of the housing is considered inadequate, and 20% of households in tribal areas lack complete plumbing. One-third of tribal area homes are overcrowded, a rate over six times the national average.

Health and Health Services for Homeless Native Americans

Homeless Native American Health Research: Given the complexities of carrying out research on a population which is both extremely diverse and transient, very little research has been published on homeless Native Americans. A handful of studies are reported here; they largely reinforce assumptions about precipitating factors for homelessness and health disparities, though a few explore potential solutions.

Health Services: The Federal government has a trust responsibility to provide health care services for American Indians on the basis of numerous treaties and legislative acts; the Indian Health Service (IHS) is the primary agency managing this responsibility. Native Americans can receive health care services directly from IHS-run hospitals and clinics, from tribal-run facilities (as per the Indian Self-Determination and Education Assistance Act, PL 93-638), or from Urban Indian programs. Yet eligibility requirements to obtain these services, and the fact that most are only available on or near reservations in rural locations, prevent many from receiving IHS services – just 1.4 of the 2.5 million Native Americans in the U.S. are eligible to receive IHS services, and just one-fifth say they actually access their healthcare through IHS. Insufficient funding for the IHS is a major part of the problem. Other sources of health care available to Native Americans, depending on their income, health status and other eligibility factors, include Medicaid, Medicare, and private insurance. Federally Qualified Health Centers (health centers) served

nearly 125,000 Native Americans in calendar year 2002. These individuals comprise just over 1% of the 11 million persons served by health centers during that period. Federal Health Care for the Homeless (HCH) projects are already serving Native American homeless individuals - one-fifth consider them a high-user population – and are likely to see even more as trends in budget cuts (for health care as well as affordable housing) continue, and as urban migration of the populations continues.

Health Care Access Issues: All of the providers we spoke with said Native Americans who are homeless in their communities will delay seeking health services in large part due to a lack of trust in organizations, especially government-run organizations. The shortage of providers in IHS-run services, and of Native American providers generally, also hinders full health care access. A combination of cultural and socioeconomic factors - including poverty - contribute to limited or delayed access to health care services. Solutions offered for overcoming these access barriers fall into two broad categories: enhance cultural awareness and knowledge, and improve communication and coordination of services with IHS and other Native-specific services.

Conclusions

The vast variation within and among Native Americans who are homeless, healthcare services and systems, tribal politics and policies, and geographic regions of the country prohibit sweeping conclusions. Nevertheless, it is clear that Native Americans are at extremely high risk for homelessness, particularly in areas currently served by HCH projects and their surroundings, are experiencing much greater health disparities than other groups in the U.S. population, and will increasingly have difficulty accessing healthcare services through the Indian Health Service if budget cuts continue and if Indians continue to migrate into metropolitan areas. The latter is only exacerbated by a profound lack of trust this population has in government-run organizations. It is therefore important simply to increase awareness and sensitivity toward the issues affecting this population, and to make every effort to collaborate with IHS services and Native-run organizations who are best equipped to provide culturally competent healthcare. While the barriers are immense, the fact that Native Americans on the whole have profound strengths within their communities and extended families should not be overlooked; to the extent possible, those strengths should be tapped as important coping strategies.

ACKNOWLEDGMENTS

Interviewees:

The individuals listed here provided invaluable information about their experiences working with homeless Native Americans; their contributions to this report are greatly appreciated.

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INTRODUCTION AND OVERVIEW

Examining differences among homeless¹ “subpopulations” has advantages and disadvantages. While the exercise can be beneficial – understanding common backgrounds garners empathy, and identifying unique service needs and experiences is important in designing effective programs – it can also detract attention from the shared realities of persons experiencing homelessness, namely lack of safe affordable housing and a lack of adequate income, and potentially reinforce biases against subgroups. In an article which touches on this conflict, the authors state it this way: “Who is vulnerable in a particular housing market should not be confused with why homelessness occurs at all. ‘Social poverty’, although it may appear differently in different subgroups, is often derived from long exposure to demoralizing relationships and unequal opportunity (Rosenheck et.al. 1992).” It is with this important caveat that this report presents information on Native Americans², an often-neglected subpopulation of homeless persons, *as distinct* from other subgroups. Specifically, this report summarizes some of the key factors contributing to homelessness and health disparities among Native Americans, discusses the unique barriers they face when trying to access health care, and suggests some short-term solutions for overcoming those barriers. The next brief sections provide broad overviews of the prevalence of homelessness among Native Americans, and of what is known about health disparities among Native Americans in the U.S. generally.

Prevalence of Homelessness Among Native Americans

American Indians are overrepresented among persons who are homeless: though they represent less than *1.5 percent* of the population in the United States, it is estimated that they make up *eight percent* of those who are homeless (OSG 1999). Among veterans, the disparity is even more salient – a national study of nearly 50,000 homeless veterans showed that while approximately 1.3 percent of veterans are Native American, they are overrepresented in the homeless population by approximately *nineteen percent* (Kaspro and Rosenheck 1998).

Although studies which assess Native American homelessness at the local level are somewhat rare, those that are available reflect the overrepresentation seen at the national level. For example, in the Denver area of Colorado, where American Indians make up one percent of the overall population, they account for about four percent of the homeless population (Draper 1998, p.2). A Seattle health care provider similarly reported that Native Americans comprise two percent of that city’s population, but are estimated to be four percent of that city’s homeless. It is not surprising that Native Americans are also overrepresented among clients served by federal Health Care for the Homeless (HCH) programs: one clinician noted that in her state of Montana, six percent of the general population are American Indian, yet they make up eleven percent of those served at her Health Care for the Homeless clinic.

It is also worth noting that Native Americans are disproportionately represented in other high-needs populations in the U.S., including people who are incarcerated, people with alcohol and drug problems,

¹ The concept of homelessness in this discussion is: “an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or nonpermanent situation. An individual may be considered homeless if that person is ‘doubled up,’ a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, previously homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. Recognition of the instability of an individual’s living arrangement is critical to the definition of homelessness (Bureau of Primary Health Care, Program Assistance Letter 99-12, March 1999).”

² Throughout this report, the terms “Native,” “Native American” and “American Indian” are used interchangeably; both terms include the Alaska Native population.

people exposed to trauma, and children in foster care (OSG 1999). Individuals in these high-risk categories are especially vulnerable to homelessness.

Health Disparities – a National Overview

Data on health disparities specific to homeless Native Americans are not available on regional or national levels, so this section of the report provides a broad overview of what we know about health disparities experienced by Native Americans in the United States generally. Because homeless persons have much greater health disparities than those who are housed, it can be assumed that the health disparities reported here are even greater among those experiencing homelessness.

National Data on Indians in IHS Service Areas

The Indian Health Service (IHS), a branch of the United States Department of Health and Human Services, systematically collects and distributes health status data on American Indians eligible for IHS services; that is, individuals deemed to be residing in “the IHS service area.” The IHS service area consists of counties on and near federal Indian reservations, which include approximately 60 percent of American Indians. The health disparities reported for this segment of the Indian population for 1994-1996 are startling. As shown in the table below, the Indian age-adjusted rates for several causes of death are much higher than those for the U.S. population as a whole; rates of death from diabetes are 46.4 per 100,000, which is 249% higher than the rate for all races in the U.S. during the same time period (13.3/100,000). (See Mortality Rates comparison table, below.). These statistics do belie some notable improvements over time, such as the decrease in infant mortality rates from 22/1000 live births in 1972-74 to 9/1000 in 1997, but overall the disparities persist.³

MORTALITY RATES			
INDIANS VS. ALL RACES IN THE UNITED STATES			
Cause of Death	All Races <i>Deaths/100,000</i>	American Indians⁴ <i>Deaths/100,000</i>	Percentage Difference
Alcoholism ⁵	6.7	48.7	+ 627%
Tuberculosis	.3	1.9	+ 533%
Diabetes Mellitus	13.3	46.4	+ 249%
Accidents	30.5	92.6	+ 204%
Suicide	11.2	19.3	+ 72%
Homicide	9.4	15.3	+ 63%

Sources: IHS 1999, Trends in Indian Health 1989-99 and Regional Differences in Indian Health 1989-1999

³ See the IHS Report “Regional Differences” cited in the Bibliography for regional variation in these statistics.

⁴ These Indian rates have been adjusted for miscoding of Indian race on death certificates (IHS 1999).

⁵ It is important to distinguish between deaths caused by behavior related to alcoholism (alcohol-dependent or chronic drinking) and alcohol-abusive drinking patterns (sporadic, binge drinking, etc.). As one researcher puts it: “...alcoholism per se is not the leading cause of death among Indians. More accurately, alcohol abuse and alcoholism combine to be the leading cause of mortality (May 1994, p.2).”

National Data on All Indians

Numerous factors confound the study of American Indians' health status and health service needs on a national level, that is, on a level which includes American Indians not living in IHS service areas. Nationally representative studies do not typically generate samples large enough to draw sufficiently accurate conclusions, and even when large samples are obtained the findings are hindered by the diversity (social, ethnic, and cultural) of the Native population (OSG 1999). Nevertheless, a recent report from the United States Commission on Civil Rights concluded:

“The prominent medical afflictions of urban and rural Native Americans are largely the same: alcohol and substance abuse, domestic and community violence, diabetes, cancer, mental illness, heart disease, poor dental health, and infectious disease (USCCR 2003, p.47)⁶.”

ÿ Self-Reported Health: Data from the National Health Interview Survey 2000 showed that 17.2% of respondents identifying themselves as Native American/Alaska Native rated their health as “fair” or “poor.” These ratings were much higher than those provided by respondents of any other race or ethnic group; for example, just 7.9% of whites rated their health as fair or poor (Kaiser 2003).

A Note on Urban Indians: Collecting data specifically on urban American Indians is complicated by: 1) a lack of clear, consistent definitions for urban Indians that local and state health officials can use; 2) the dispersion of urban Indians throughout metropolitan areas; and 3) their extremely high residential mobility, especially among low-income individuals and families (Forquera 2001, p.6).

ÿ One population-based study published in the *Journal of the American Medical Association* in 1994 represents a rare attempt to characterize the health status of the urban American Indian population and compare it with those on reservations and with urban whites and African Americans. Large disparities were found between the urban American Indian population and the urban whites, but no consistent pattern was found when comparing urban and rural (reservation-based) American Indian populations, though those in the urban areas had higher rates of low birth weight and lower rates of prenatal care use (Grossman et.al. 1994).

It should be noted that this crisis in racial health disparities for Native Americans is being discussed and actively addressed across the country. Some examples of national discussions about these disparities include: The “National Forum on Health Disparity Issues for American Indians and Alaska Natives” (held in Denver, Colorado on September 22-26, 2002) and the 2003 Annual Conference of the Association of American Indian Physicians entitled “Eliminating Health Disparities in Indian Country” (held July 31-August 5 in Santa Fe, New Mexico). The Indian Health Service has also launched a Prevention Initiative, charging a Task Force to design and implement clinical and community based health strategies to prevent disease and promote health. To date, however, the specific disparities experienced by homeless Native Americans have not been discussed in a national forum.

This Report

The information in this report has been gathered from a variety of sources, including: interviews with persons currently providing health care to Native Americans who are homeless⁷, peer-reviewed published

⁶ A Kaiser Family Foundation report attempts to draw available population health indicators together in a summary report entitled “Key Facts: Race, Ethnicity, and Medical Care (Kaiser 2003).” When health indicators are available for American Indian persons, they reinforce health disparities seen in the IHS data.

⁷ Please see the Acknowledgments section of this report for a list of these individuals.

research, and government publications and resources. Where possible, instructions for accessing publicly-available resources referenced in the text of this document are listed in the Bibliography of this report.

The body of this report is organized into two major sections. The first section describes key factors contributing to homelessness and/or health disparities among Native Americans. The factors summarized here include historical context and dispossession, demographic characteristics, urbanization, and housing problems. The second section of this report examines more specifically what is known about the health of homeless Native Americans, describes what health care services are available to them, and explains some of the major barriers they face in accessing the health care they need. Finally, tentative short-term solutions are offered for overcoming these barriers.

FACTORS CONTRIBUTING TO HOMELESSNESS AND HEALTH DISPARITIES

History

An understanding of the brutal and genocidal history of American Indians in North America is vital to any discussion of their contemporary experiences. Though an incredibly diverse group (see “racial/ethnic diversity” discussion below), some shared experiences of all Native American persons include:

- The forced, rapid change from a cooperative, clan-based society to a capitalistic and nuclear family-based system;
- The outlawing of language and spiritual practices;
- The death of millions of their ancestors due to infectious European diseases and/or the slaughter of war; and,
- The loss of the ability to use land occupied by their ancestors for thousands of years (OWH 1996).

These experiences have understandably influenced general health and well-being, and potentially behaviors when seeking and receiving health care services, including a profound suspicion of government authority.

“...the historic treatment of Indians and the emotional effects of these actions inhibits urban Indians from seeking help from non-Indian organizations, even when eligible. ... we cannot forget the importance of history, experience and the emotions of those we are trying to help, regardless of their proportional size in a given region (Forquera 2002).”

The profound and far-reaching impact of this dispossession on Native Americans cannot be overstated. It lies at the root of the physical and mental health of Native American individuals and families, and of the availability of - and their access to - the informal and formal supports they need. In research reported later in this report, it is clear that at least in some cases out-of-home placement policies have led to homelessness.⁸

⁸ One example of this is the Federal Indian Boarding School Movement, begun in 1875, which attempted to eradicate Native culture by forcing separation of Native children from their parents and sending them to boarding schools where they were not allowed to use their native language, see their families, or practice cultural rituals and traditions (OSG 1999). Researchers continue to debate the impacts of this experience on the children, on their parents, and on the parenting experiences of the children once they became parents themselves (e.g. see Stout 2001).

COMMENTS ON HERITAGE AND HEALTH

“The link between heritage and health is key for sustaining healthy Indian people and communities (RIW 2002, p.40).”

An Arizona psychiatrist working in a walk-in psychiatric clinic for Native Americans comments: “Successful people are built on stable family, community and shared culture, mores and history. For tribal people several of those stanchions are destroyed or severely altered. These are traumatized, victimized families. Not for a few years, or a decade or two, but for a couple of hundred years. They lost their homes, their tribes were decimated, children were taken from their parents. This happened until 1978... (Nichols July 2002).”

“The factor that separates homeless Native Americans who recover from those who die is spiritual values. Clients who have abandoned their heritage can’t grieve properly over such historical events as losing their land, or when dealing with personal trauma. They don’t apologize or ask forgiveness from their ancestors. They continually relive their problems and turn to self-medication. We see much generational grief (Kenneth McMillen, MD, AIHCDC, Minneapolis, Minnesota).”

Demographic Characteristics

A Diverse and Growing Population

Native Americans are an extremely diverse population, representing numerous cultures and languages, and are also a young and fast-growing population. These factors serve as potential barriers both to tracking and documenting health status, but also to providing appropriate and accessible health care services.

Racial/Ethnic Diversity

Native Americans comprise 569 different federally recognized tribes that speak more than 200 indigenous languages. There are also an unknown number of non-federally-recognized tribes. About 280,000 speak a language other than English with their families; more than half of Alaska Natives considered Eskimos speak either Inuit or Yup’ik (OSG 1999).

Population Growth

The Native American population increased by nearly two-fifths (38%) between 1980 and 1990 and another 9% between 1990 and 1996 (compared with 3% growth among whites), largely due to an increasing number of individuals self-identifying as American Indian, an increase in the population’s birth rate, as well as better data collection by the Census Bureau (OSG 1999). For the 2000 Census, which for the first time gave participants a choice of self-identifying American Indian/Alaska Native as their only race or as one of multiple races, 2.5 million persons identified Native American as their sole race, but 4.1 million claimed to be Native American in combination with one or more other races. By 2020, the number of individuals self-identifying their sole race as Native Americans is expected to grow to 3.1 million.

Young Population

According to Census 2000 data, just over one-quarter of the U.S. population (26%) are under the age of 18; this compares with one-third (33%) of American Indians. Similarly, 12% of the total U.S. population is over the age of 65, but just 6% of those who self-identify as American Indian are this old (U.S. Census 2000).

Economic Disadvantages

Native Americans are at a severe economic disadvantage, compared with the U.S. population as a whole. Factors such as low income, education, and employment create tenuous financial situations which can lead to homelessness and related problems, including poor health and limited access to quality health care.

Poverty

According to the Census Bureau's Population Survey from 2002, over half (54%) of the Native American non-elderly population were considered poor. Specifically, 29% were living at less than 100% Federal Poverty Level (FPL) and an additional 25% were "near poor" (living at 100-199% of the FPL). This compares with 25% of white respondents who fell into both of these categories combined. Elderly Native Americans fared less well, with 61% either "poor" (20%) or "near poor" (41%) - again far higher than 40% of whites (Kaiser 2003).

High Unemployment

The unemployment rate for Native Americans nationally is 12.4%, or approximately twice as high as the national average. The situation is even more dire on reservations, where the unemployment rate averages 31% (e.g. among the Navajo it is 25%; those on the Kickapoo reservation in Texas have an unemployment rate nearing 70%) (USCCR 2003, pp.8-9).

Fewer High School and College Graduates

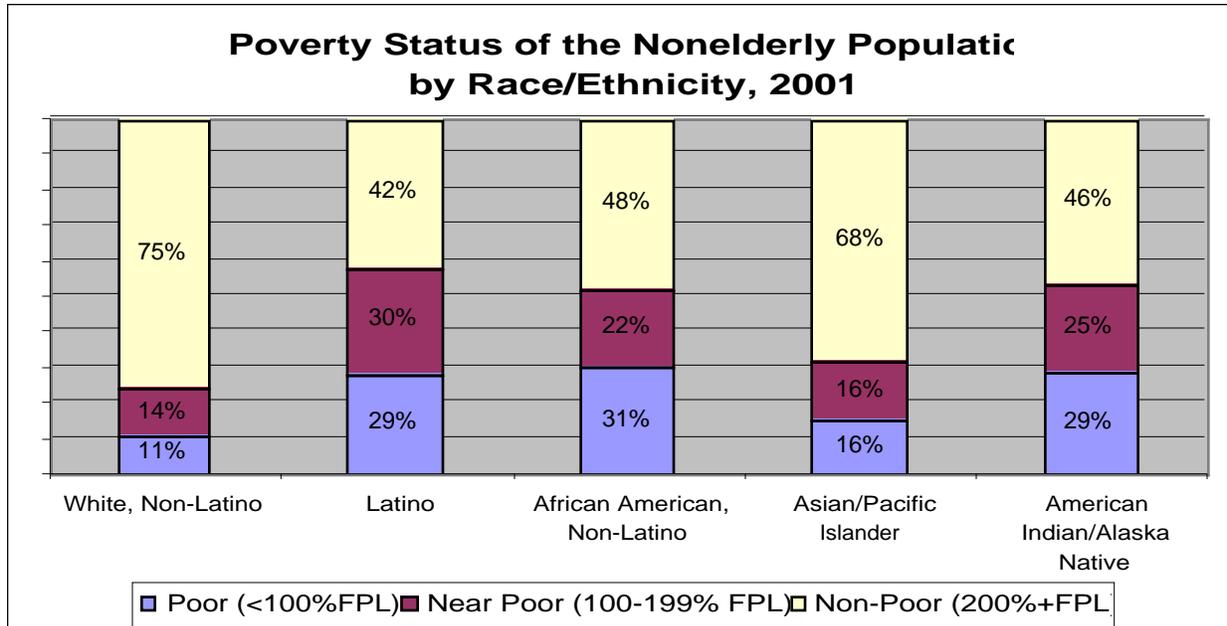
Two-thirds (66%) of American Indians ages 25 years and older have achieved at least a high school diploma. Though an increase over the 56% who had achieved this in 1980, it still remains lower than for the U.S. population as a whole (75%) (OSG 1999). Among Native Americans ages 25 and older, just 9.4% have had four or more years of college; this compares with 20.3% nationally (USCCR 2003, p.9).

More Female-Headed Households

The proportion of American Indian families headed by a single female increased 27 percent between 1980 and 1990; this increase was even more rapid than in the nation as a whole (17%) (OSG 1999).

Larger Families – Higher Dependency Index

In 1993, American Indian families were slightly larger than all other U.S. families, with 3.6 versus 3.2 persons per family. More telling, perhaps, is the fact that American Indians had a much higher "dependency index." The dependency index compares two groups: 1) the proportion of household members between 16-64 years of age; and, 2) those younger than 16 years and older than 65 years. The index assumes that the former group is more apt to contribute economically to the household and that the latter are therefore (economically) dependent. In many Native American communities, the dependency index is far higher than it is among other groups in the U.S. population – one source notes that "households in many American Indian communities exhibit much higher dependency indices than other segments of the U.S. population and are more comparable to impoverished Third World countries (OSG 1999, Chapter 4)."



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2002 Current Population Survey – reprinted from Kaiser 2003, p.5.

Environmental Factors

Native populations reside in unhealthy environments more frequently than do other U.S. groups. As noted below, they are less apt to have safe water and more likely to live near toxic waste sites. In addition to the obvious health consequences of living in these conditions, these environmental hazards also impact many of the plants and herbs which form the basis of medical knowledge and practice among these populations (OWH 1996, p.4).

Safe Water and Waste Disposal

Safe water and adequate waste disposal facilities are lacking in 7.5% of Indian homes; this compares with 1% in the U.S. general population (RIW 2002, p.4; USCCR 2003, p.48).

Toxic Waste Sites

Half of all American Indians live in areas with uncontrolled toxic waste sites (OWH 1996, p.4). In an article by Native Environmentalist Winona LaDuke, she notes that Native lands are “attractive to industries searching for disposal sites for nuclear waste. In the past four years, more than 100 separate proposals have been made by government and industry to dump waste on Indian lands. To date, Indian communities have received 16 of the 18 "nuclear waste research grants" issued by the US Department of Energy (LaDuke 1994).”

HEALTH AND THE ENVIRONMENT

The environment plays an especially significant role in Natives' holistic view of health.

Recommending that the IHS include environmental health in its mission, a Restructuring Initiative Workgroup commented:

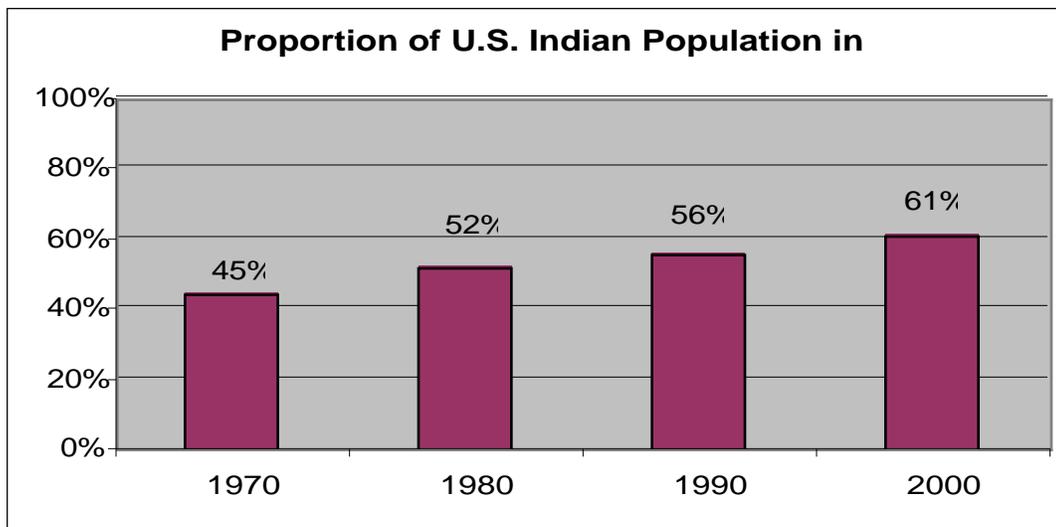
“...to American Indians wellness is a state of harmony and balance among mind, body, spirit, and environment. If the environment is unhealthy, the state of wellness is compromised (RIW 2002, p. 22).”

A Native American physician similarly said:

“Our belief is that if we take care of the air, fire, earth and water spirits, they will take care of us. Our aim is to live in balance with the world and with our inner selves (Lamberg 2000, p.1370).”

Urbanization

Most American Indians reside in western states, including California, Arizona, New Mexico, South Dakota, Alaska and Montana; in general, they are more likely than whites to live in rural areas (OSG 1999). In the past few decades, though, the number living on reservations or trust lands has decreased significantly; in 1970, less than half (45%) lived in urban areas, compared with 61% today (Kaiser 2001). This migration has been occurring over the past century and is expected to continue; historically, it reflected federal government “relocation” policies in effect during the 1950s, though today it reflects a search for employment, education and housing opportunities which are often limited on reservations (Kaiser 2001; see also Draper 1998). For homeless Native Americans, several HCH providers we interviewed suggested an original departure from the reservation might also be predicated by some traumatic event related to mental illness or substance abuse. When the latter is the case, it can make a return to the community and homeland - critically important social support systems - even more difficult. Regardless of the impetus, though, the migration of American Indians off the reservation and into urban areas is continuing, and has serious consequences for provision of health care.



Source: Kaiser 2001, p.5; 2000 U.S. Census

Two characteristics of this urban migration both contribute to homelessness and stymie efforts to serve those at risk of homelessness: the cyclical nature of the migration, and the dispersion of American Indian populations in cities.

Cyclical Migration

The pattern of Indian urban migration from reservations to cities is often cyclical rather than direct; that is, though Indians may leave the reservation to seek opportunities in cities, they return periodically to their reservations to maintain family and cultural connections (Kaiser 2001). In fact, some estimate that a third live in urban areas, another third live on reservations, and a third move back and forth between the two (OWH 1996, p.1).

In an Issue Brief on Urban Indian Health, Ralph Forquera of the Seattle Indian Health Board points out that this cyclical migration pattern results in urban Indian populations which are highly diverse and likely to include members of various tribes which may or may not have historical, cultural or religious ties. This has a tendency to lead to social isolation and limited community cohesion and support. Native Americans may also find themselves interacting on a daily basis - in shelters or treatment facilities - with individuals who are members of cultural groups with whom they have long-term enmity. For example, homeless people from Pueblo groups in Arizona and New Mexico may find themselves interacting with homeless Dine (Navajo) people from the same geographic area in which there have been long-term disputes over land and other resources.

Interviewees from Health Care for the Homeless programs across the country agreed that some of the Native Americans they served had left the reservations due to lack of job opportunities, but attempted to make the trek back whenever possible to reconnect with family and friends. For many other clients, however, the original departure from the reservation occurred only after severely rupturing ties with family and friends – for example, resulting from episodes related to mental illness or substance use – which makes any return to the reservation on the one hand more important for social and economic survival, and on the other one fraught with personal shame.

It is also important to note that cyclical migration patterns are indicative of a distinct concept of home and homelessness. Homelessness is typically defined as being without a shelter, but for many Native Americans the concept of “home” is defined much more broadly, and is often directly linked with tribal lands or reservations. “A place to call home can mean Indian Country, a particular neighborhood, or the reservation (AIPC 1995, p.8).” Therefore, “home” may not always mean an individual house or structure that someone resides in, and “homelessness” may have a more comprehensive meaning than simply being without a shelter. Being “homeless” can imply a lack of connectedness to family/community for persons of all races experiencing the harsh realities of living without reliable shelter, but for Native Americans who define their home as Indian Country or the reservation, homelessness may contribute to additional disconnectedness to their heritage and roots.

“What is different about urban Indian homelessness, from my experience, is the sense among man of the loss of a social and cultural connection to the concept of ‘home’...This sense of loss and the emotional consequences they derive confounds the problem, shrouding our efforts to help because of a historical and cultural dimension that may differ from other groups (Forquera 2002).”

An organization in Minnesota held focus group discussions with American Indians about their experiences moving back and forth between the city and the reservation; in one of these groups a participant described it this way:

“I go back to White Earth [reservation] but it always feels like you’re homeless. It’s hard to get back into the community if you’ve been an outsider (AIPC 1995, p. 2).”

THE MEANING OF HOME⁹

American Indians from Minnesota discussed the concepts of home during a community discussion on the topic (AIPC 1995, pp. 8-10). Following are some of their comments:

- ◆ “My home is within Indian country. It’s not a street address.I’m not talking about ownership or rental, but belonging to a place.”
- ◆ “One thing that strikes me for Indian people is the idea of home being the reservation, not the urban environment. After owning two homes here, I still think one day I will go home to the reservation. Many who live here in the urban area may still consider the reservation their real home.”
- ◆ “Those of us who are homeowners in the urban area, even with 30-year mortgage, view this as a temporary state. We will or desire to go back to our homeland.”
- ◆ “We can still go home and have relatives who will take us in. We have a safety net we carry around. A decision to purchase [a house] is almost giving up the safety net.”
- ◆ “When you’ve got 10,000 years of migratory patterns in your cells, is planting in one place right for you? If you can say: ‘I can go back to the reservation’ you still have sense of movement.”

Population Dispersion in Metropolitan Areas

Unlike some racial subgroups, Native Americans tend to be dispersed throughout metropolitan areas rather than to reside in concentrated communities. Though it has not been studied, it appears this phenomenon may occur less frequently among Native Americans who are impoverished or homeless. For example, impoverished American Indians congregate in a small area called the “Indian Gulch” in San Francisco, in Chicago a similar community is referred to as “Little Earth,” and in Albuquerque it is “Indian Alley.” Nevertheless, this overall population dispersion has an impact on service provision for Native Americans generally. A report on American Indians in Los Angeles County stated some of the problems this dispersion causes:

“This dispersed residential pattern presents a sizeable barrier to providing services to the American Indians community. Traditional place-based strategies such as neighborhood-based community development, education and outreach are less effective given the dispersed client base (Ong and Houston 2002).”

⁹ In this same study, researchers explored some of the barriers to home ownership. A key finding from this study was that the complexities involved with the process of purchasing a home, combined with mistrust of historically white-dominated systems, can become a real barrier. The study found many participants did not understand that the homeowner can benefit from making such a long-term commitment when it appears only the white bankers will profit, or that they could sell the house to get out of the commitment if it became problematic or burdensome.

Housing Problems

As noted above, urbanization has contributed to social isolation among many Native Americans and hindered the ability to serve those at risk of homelessness; exacerbating the situation is the fact that many face a severe housing shortage - and discrimination – impeding the way when attempting to acquire safe, affordable housing in those metropolitan areas.

Housing Problems in Metropolitan Areas

Housing Shortage

Over the past two decades, the number of affordable housing units has decreased significantly for those with low incomes. “Between 1973 and 1993, more than 2 million low-rent housing units disappeared from the market. At the same time, the number of low-income renters increased by nearly five million (HRSA 2003, p.3).”

Discrimination

Native Americans, like many minority groups in the U.S., may encounter several types of discrimination while trying to purchase or rent housing.

- **Home Ownership:** At least one study of Home Mortgage Disclosure Act (HMDA) data has demonstrated a disparity in rejection rates of loan requests between whites and Native Americans. And, a review by the National Community Reinvestment Coalition concluded that, “on a national level, Native Americans are two times more likely than whites to receive high cost mortgage loans.” In South Dakota and New Mexico, the gap is even greater, with Native Americans three and six times more likely than whites (respectively) to receive high cost mortgage loans. The report warns: “Because Native Americans disproportionately receive high cost loans, they are especially vulnerable to predatory lending (NAIHC/NCRC 2003; see also AIPC 1995).”
- **Rental Housing:** The Department of Housing and Urban Development recently completed its first study on housing discrimination to include Native Americans, and concluded that in the three metropolitan housing markets studied (Montana, New Mexico, and Minnesota) “American Indian renters face significant levels of discrimination, primarily due to denial of information about the availability of housing units (Turner 2003).” Several of the Health Care for the Homeless clinicians interviewed for this report stressed the existence of discrimination their Native American clients experience when trying to access safe rental housing. (“Especially single moms with two or more kids – it’s very hard to find housing in safe neighborhoods.”)

Other Barriers

A few clinicians noted a common quandary facing some of their clients– as soon as they move into a rental unit or other housing situation, their relatives move in; because kicking out relatives is not an option, they end up losing their housing. As one Native American clinician said, “If you’re Indian, you have to be a good relative.” The Executive Director of the National American Indian Housing Council described the impact this dilemma has on overcrowding: “Native Americans are reluctant to say no to relatives or those less fortunate – and thus their problem becomes one of vast overcrowding (NAIHC 2002).”

Housing for Native American Homeless Individuals in Urban Areas

Examples of Innovative Programs

- ▼ Anishinabe Wakiagun (meaning “The People’s Home” in the Ojibwe language) was completed in 1996 as the first housing development project of the American Indian Housing and Community Development Corporation. This is a culturally-specific permanent supportive housing program for chronically intoxicated, homeless men and women in Hennepin County, Minnesota. Residents are encouraged to achieve sobriety, but also to participate in traditional spiritual activities and to fully explore their arts and crafts skills.
- ▼ With moneys from the Minneapolis Neighborhood Revitalization Program and the Minnesota Housing Finance Agency, the American Indian Housing and Community Development Corporation has helped renovate boarded-up housing in the area, including an apartment building (called “On Eagle’s Wings”), duplex housing (“Many Rivers Apartments”), and townhouse units (“Pokegama”). In addition, Habitat for Humanity has partnered with AIHCDC to encourage Native American families to apply for Habitat housing.
- ▼ Collaboration between the Native American Health Center and the East Bay Asian Local Development Corporation in Oakland, California, has resulted in development of a new 38-unit affordable housing mixed-use project. The six-story structure will include a 24,000 square foot holistic health care facility, community gathering space and outdoor ceremonial gardens for the Native American Health Center. Community members will be consulted in designing the building, which will incorporate Native American architectural themes in the structure.
- ▼ The Urban Indian Housing Program provides counseling workshops for prospective homebuyers that addresses cultural values, such as whether a house that is owned can be shared among the extended family, or passed to the next generation within a family. (This program was developed by the American Indian Policy Center - www.airpi.org.)

Housing on Reservations

As noted previously, the shortage of safe, adequate housing – along with limited employment opportunities - on Indian reservations has contributed to the increased migration of Native Americans into American cities. It is also important, however, to understand the housing situation on reservations because of the ties many Native Americans retain there and face when they return. Following are some of the housing issues affecting individuals who live on reservations.¹⁰

Housing Shortage

Waiting lists for housing on many reservations are long – the Tribal Court Clearinghouse reports 30,000 people are on the waiting list for rental housing in tribal areas in Indian Country, a number which would fill Indian Country’s existing low-income rental units; the housing shortage is acute. Individuals wait an average of 41 months for low-income rental housing in Indian Country, compared with 21 months elsewhere. Tribal leaders, many of them Sioux, in South Dakota and Montana, declared housing and health emergencies to draw attention to what they perceived as the failure of the Bureau of Indian Affairs

¹⁰ See the United States Commission on Civil Rights report from July 2003 for a detailed description of the factors which hinder provision of adequate housing on reservations and tribal lands. (USCCR, 2003, “A Quiet Crisis: Federal Funding and Unmet Needs within Indian Country.”)

to address their housing situation. Given the rate and amount of aid provided to those in need, tribal leaders said “it would take an individual 35 years before we can get to them. It’s misleading for the tribe to give the applications to the members and know we will never, ever get to them unless they’re 5 years old when they apply (Donovan 1998).”

Housing Conditions

According to the Council of Indian Nations, housing conditions on reservations in Arizona, Nevada, New Mexico, and Utah are among the worst in the United States. Existing housing structures are described as “substandard: approximately 40 percent of on-reservation housing is considered inadequate, and one in five reservation homes lack complete plumbing (USCCR 2003, p. x).” The Department of Housing and Urban Development (HUD) has made efforts to improve the situation, but progress is hindered by lack of funding. Geographic isolation and harsh environmental conditions also make construction difficult and expensive (USCCR 2003).

Overcrowding

A February 2002 report from the National American Indian Housing Council declared overcrowding a worse problem on American Indian reservations than homelessness, though for purposes of this report the definition of homelessness *includes* situations in which individuals are “doubled up” and/or living in unstable housing. Using the U.S. Census criteria for overcrowding – more than one person to a room – one-third (32.5%) of all Indian housing and 40% of Alaska Native housing is overcrowded. These rates are, respectively, six and eight times more than the rate (4.5%) for the U.S. as a whole (NAIHC 2003).

The Pine Ridge Reservation in South Dakota is among the poorest areas in the United States: “One-third of the 40,000 population of Pine Ridge are considered homeless. It does not mean thousands are sleeping on the street. It means literally that thousands are crammed into houses that are built for small families (Pathways to Spirit newsletter, Winter 2003).”

The report further states that the nature of overcrowding in Indian communities is also changing: “Whereas previous generations were likely only to invite extended family to live with them, currently there are more ‘compound’ households – those that mix relatives and non-relatives (cited in Fogarty 2003; see also USCCR 2003).” Speaking of Indian Country as a whole, another recent report on housing conditions observed: “Homelessness is ... becoming increasingly visible on reservations,

with families living in cars, tents, abandoned buildings, or storage sheds (USCCR 2003).” Overcrowding, like homelessness, has detrimental effects on health: “Detrimental effects include a variety of physical health problems such as respiratory illnesses, skin conditions, alcoholism, sleep deprivation – as well as social ones: lack of privacy, children’s lackluster performance at school, etc. (NAIHC news release, 2002).”

Housing for Native American Homeless Individuals on Reservations
Examples of Innovative Programs

- ✓ The Pathways to Spirit organization emerged in response to the dire housing situation on reservations in Pine Ridge, South Dakota. Since 1999, the program has moved 101 mobile homes (used and in good condition) to the reservation – relying on fundraising efforts to find the \$800 required to transport each mobile home (Pathways to Spirit newsletter, Winter 2003).
 - ✓ The Walking Shield American Indian Society developed the Operation Walking Shield program in 1994. This program collaborates with Air Force Bases in North Dakota and Montana to take excess military housing units slated for demolition as part of military downsizing, winterize and renovate them, and move them to Indian reservations in North and South Dakota and Montana. “This project saves military and taxpayer money by avoiding costly demolition of the units and removal of the debris (Operation Walking Shield website: www.walkingshield.org/operation.htm).”
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HEALTH AND HEALTH SERVICES FOR HOMELESS NATIVE AMERICANS

Homeless Native American Health Research

In this section of the report, only those research studies which have assessed health status issues among Native Americans who are homeless are reviewed. On the whole, these studies are small-scale attempts to represent specific populations, but are nevertheless helpful in validating or challenging common assumptions, and in raising relevant issues.

Experiences with Homelessness

These studies confirm that childhood out-of-home placement continues to be a contributing factor to homelessness, but also that Native American homeless persons may have stronger social support resources than other subgroups. Nevertheless, they are more apt to face cultural and systems barriers when trying to access public services.

- A study in the San Francisco Bay Area (California) and Tucson (Arizona) assessed qualitative research done with American Indians and identified the following as factors precipitating homelessness: “a complex interaction of childhood fostering or adoption into non-Native families, different types of involuntary institutionalization during youth, and the personal impact of accident, trauma and loss (Lobo and Vaughan 2003, research abstract).” These authors also identified several coping strategies among Native Americans, including the use of service organizations, the role of extended family, and cultural resiliency.
- Another study from Minneapolis, Minnesota, focused on the extent to which the experience of homelessness differed between indigenous and white populations in the city. A predominately male group of 76 indigenous and 143 white homeless persons completed surveys. Results indicated more than half (55%) of the indigenous groups had experienced childhood out-of-home placement (compared with 40% of whites) and had higher levels of disability related to alcohol use and its consequences. Findings on social supports differed between these groups as well: while both groups said they had families who cared about them, indigenous persons reported significantly more contact with families in the prior 30 days and reported receiving more shelter and food from friends. However, two-fifths of indigenous persons (compared with one-third of whites) had not received public assistance during the preceding month (Yellowbird 1999).
- A survey of 335 older Native Americans living in Los Angeles County in 1987-89 found 16% of them were homeless. Compared to the housed Native American elderly surveyed, these homeless Native Americans were younger (median age 53 compared with 58 years), but self-reported higher rates of physical and mental health problems which included hypertension, alcoholism, depression, diabetes, chest pains, sadness and loneliness. These researchers conclude that “institutional and cultural barriers prevented some homeless individuals from accessing social and welfare services (Kramer 1996, research abstract).”

Substance Dependency

Substance dependency is strongly associated with homelessness, and the Native American subpopulation is no exception. As one of these studies shows, homeless Native American veterans experience more severe alcohol problems than other minority groups, but fewer problems with drugs and psychiatric issues. Another author warns that drinking patterns (e.g. sporadic, binge drinking) may be more of an issue than alcoholism. Nevertheless, these studies on interventions suggest that those which work with

other minority populations (such as intensive case management) may be equally successful with Native American homeless individuals.

- *Prevalence– Homeless Veterans:* One study of data on homeless veterans compared psychiatric and substance abuse problems of Native Americans with other ethnic groups in the population. Results indicated not only that Native Americans were overrepresented in the homeless veteran population (by 19%), but also that they reported more severe alcohol problems than the other minority groups – as measured by current alcohol abuse, more previous hospitalizations for alcohol dependence, and more days of recent alcohol intoxication. However, Native American homeless veterans reported fewer drug dependence problems, fewer current psychiatric problems, and fewer previous psychiatric hospitalizations (Kaspro and Rosenheck 1998).
- *Interventions:*

Native Americans represented approximately 13 percent of a group of homeless alcohol-dependent individuals in a study of substance abuse interventions at a large day shelter in Albuquerque, New Mexico. Randomly assigned to either a behavioral intervention (Community Reinforcement Approach) or standard treatment, participants of all racial groups who participated in the CRA had improved outcomes on drinking behaviors, employment, and housing stability up to one year later (Smith et.al. 1998).

A similar study, with one-third of the sample comprised of Native American women and men, found relative success of a long-term intensive case management intervention among severely disabled chronic alcoholics (Cox et.al. 1993).

Another study assessed health care service use among chronic inebriates in Minneapolis Minnesota and found ethnic and gender-specific supportive housing programs and intensive street case management reduced health care use for most patients; 60% of those in the study were Native American. The authors note, however, that a very small number of patients with serious medical illness or injury are heavy contributors to resource utilization, especially emergency services (Thornquist et.al. 2002).
- *Dispelling Myths:* Though not homeless-specific, one important article surveys the scientific research and dispels numerous myths about American Indians and alcohol use which continue to be found in the research and general literature (May 1994). Some of the author’s conclusions include:
 - ⇒ It is important to distinguish between alcoholism (alcohol-dependent or chronic drinking) and alcohol-abusive drinking patterns (sporadic, binge drinking, etc.). The latter is frequently a cause of a large proportion of mortality rates attributed to alcoholism.
 - ⇒ There is no scientific basis for the myth that Indians metabolize alcohol differently from other ethnic groups;
 - ⇒ Explanations of high rates of alcohol-related problems and their solutions can be found in demographic, geographic, political and cultural variables that are not necessarily uniquely Indian (e.g., the fact that Indian populations are young, have lower socioeconomic status, and live in higher risk environments);
 - ⇒ The overall prevalence of drinking among Indians is not the most important variable in the epidemiology of drinking. What is more important are the drinking styles, some of which emphasize very problematic behaviors¹¹; and,

¹¹ In one of the housing programs referenced earlier in this report, the “Anishinabe Wakiagun” permanent housing program for chronically intoxicated, homeless men and women, the founders had to redesign their visitation rules in the program once they learned their Native American residents preferred drinking in groups rather than alone. This is one of the “drinking styles” this author is referring to in this article.

⇒ One of the ways in which the “Drunken Indian” stereotype is perpetuated by available statistics is the reporting of highly duplicative counts in estimating problems and prevalence. For example, a chart review of IHS records in the U.S. Southwest over a period of 10 years found four-fifths (83%) of the inpatient episodes of one-fifth (21%) of the individuals were for alcohol-related illness; these individuals were responsible for 53% of outpatient visits.

Risky Sexual Behaviors

These studies suggest that while being American Indian may place women at greater risk for sexually transmitted diseases, their willingness to use contraceptive methods more often may be greater than expected.

- Using surveys to ask a representative sample of 764 homeless women in Los Angeles questions about contraceptive use, researchers found Native Americans reporting relatively low use of virtually all contraceptive methods. The study also found gaps between reported use and willingness to use contraceptive methods among all ethnic subgroups, suggesting this could represent an opportunity to prevent unintended pregnancies and STDs (Gelberg et.al. 2001).
- Attempting to predict risk for gonorrhea infection among drug users (not in treatment) in Anchorage Alaska, researchers found two of the risk factors for women included being American Indian or Alaska Native, and perceiving themselves as being homeless (Paschane et.al. 1998).

Health Services

This section briefly describes health services currently available to Native Americans (homeless as well as stably-housed) and some of the limitations of those services. On the whole, it is clear that basic health care needs are not being met for American Indians.

Indian Health Service Delivery System¹²

As a result of a trust relationship between the federal government and Indian Tribes in the United States, the Indian Health Service is designated responsibility for providing federal health services to American Indians and Alaska Natives. The mission of the IHS, in operation since 1955, is “to provide a comprehensive health services delivery system for American Indians and Alaska Natives with opportunity for maximum Tribal involvement in developing and managing programs to meet their needs (IHS 1999).”

The IHS provides services through three types of health programs:

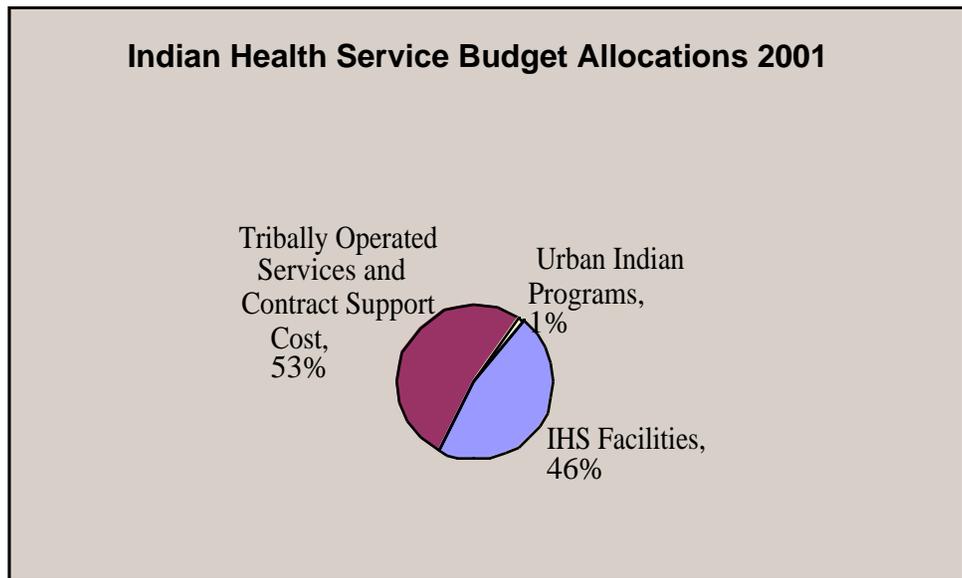
- directly through its own hospitals or health centers;
- through contracts or compacts with tribes to operate health centers or hospitals themselves. Tribes can exercise their self-determination either by taking over the operation of an IHS facility via a contract (as per the Indian Self-Determination and Education Assistance Act of 1975 - P.L. 93-638), or a self-governance compact (P.L. 93-638 Title III).¹³ ;or,

¹² A detailed description of the history of Indian Health Services can be found in USCCR 2003.

¹³ Amendments passed in 1988 enable tribes to compact with the Federal government obtain more power and independence in the management of their health programs (Title III). More recent amendments created the Tribal Self-Governance Demonstration Project, and clarify the contracting and compacting process.

- through Urban Indian programs – under Title V of the Indian Health Care Improvement Act. Funding for these programs comes from the IHS, but is also dependent on reimbursement (from Medicaid) and other funding sources, such as grants.

As shown in the table below, slightly less than half (43%) of the 2001 Indian Health Service budget was spent on IHS-run facilities, 53% went to tribally-operated services, and just one-percent is spent on Urban Indian health programs.



All services provided by the IHS and tribes are technically provided free-of-charge to members of federally recognized tribes and their descendants. However, in Urban Indian clinics, an expanded definition of eligibility holds, as they serve: “persons of Indian descent belonging to the Indian community served by the local facilities and program” which includes “those regarded as an Indian by the community in which he/she lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation, or other relevant factors (Kaiser 2001).” Since the Urban Indian programs serve people who are not members of federally recognized tribes on a sliding scale and are prohibited from discriminating in their provision of services, they end up applying their sliding fee scales to all of their patients. To receive contracted services, individuals are additionally required to reside in the contract health service delivery area designated by the IHS.

IHS eligibility restrictions mean that many Native Americans do not have access to IHS health care: just 1.4 million of the 2.5 million (or 4.1 million if one includes multi-racial Native Americans) are eligible to receive health care through the IHS (OMH 2002). And, because Indian Health Services clinics and hospitals are primarily located on reservations, just one fifth of American Indians report accessing their healthcare from IHS (Brown et.al. 2000; see also: Cunningham 1993). “Few IHS facilities, whether operated by the agency itself or by tribes, are located in urban areas. Notable exceptions are the three IHS medical centers located in the urban areas of Anchorage, Alaska; Albuquerque, New Mexico; and Phoenix, Arizona (Kaiser 2001, p.7).” The impact of rurally-based health services can be found in a local example from the annual Community Needs Assessment the Indian Walk-In Center of Salt Lake City, Utah conducted in 1998. Transportation was cited as a major access barrier, with nearly half (45%) reporting that they traveled for their health care, primarily to reservations up to 1300 miles away. It is

also noteworthy that of the approximately eighty percent who do not access IHS services, a disproportionate percentage do not have any health insurance. In summary, the effect of IHS eligibility rules is frequently to exclude most urban Indians from services provided through IHS or tribally-run facilities; this both increases the prevalence of homelessness in urban areas and makes it more difficult to address the needs of homeless Native Americans in urban areas.

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Furthermore, IHS does not have sufficient funding to provide comprehensive health to those who are eligible. For example, the IHS spends \$1,920 per capita annually, which compares with more than \$4,390 private insurance

budgets for most Americans' health plans, or the federal government's allotment of \$3,859 for Medicaid, \$5,600 for Medicare, or \$5,700 for veterans. A study conducted by a group of Indian health and tribal leaders concluded that the 2002 budget of \$3.2 billion would have to be increased more than \$7 billion annually to enable the IHS to provide care comparable to that provided to other Americans (cited in Nichols, April 2002). Many of the IHS facilities are gravely lacking resources, being forced to focus on reactive, rather than preventive, health care (e.g. see USCCR 2003; Nichols, April 2002; and DeGette 2002). A recent thorough review of funding mechanisms for health care in Indian Country concluded the following:

“The greatest travesty in looking at the deplorable health of American Indians comes in recognizing that the vast majority of illnesses and deaths from disease could be preventable if funding [were] available to provide even a basic level of care (USCCR 2003, p.49).

Urban Indian Programs

In his Issues Brief on Urban Indian Health, Forquera demonstrates that Urban Indian programs have comprised approximately one percent of the IHS budget (ranging from .09-1.48%) since 1979 (see previous table). This is not reflective of the increased need in urban Indian clinics resulting from the marked increase in Indians migrating to urban areas, described earlier in this report (Kaiser 2001). For example, when the Phoenix Indian Medical Center was built in 1970 it had capacity for 40,000 annual outpatient visits. In 2001, the clinic reported 250,000 outpatient visits; one observer commented “Part of the problem is the exploding urban Indian population...Now, more than 56,000 urban Indians rely on the center (Nichols, July 2002).”

Non-IHS Resources

Homeless American Indians may also be eligible for other health care resources, including Medicaid, Medicare, health insurance, and homeless services, depending on their financial, residential and health status.

Medicaid

Medicaid is an important source of financial assistance for eligible Native Americans. In 1996, it was estimated Medicaid covered 40% of the Native American population (Kaiser 1997, p.2; see this same report for detailed information about Medicaid policies and their effects on Native Americans). While it is beyond the scope of this paper to explore Medicaid policy issues in detail, it is noteworthy that a

distinction is made: the federal government matches costs of services to Medicaid beneficiaries of a hospital, clinic, or other IHS facility or by a tribe or tribal organization at a rate of 100% (as per a Memorandum of Agreement in 1996 between IHS and the HCFA), but this provision does *not* apply to urban Indian programs. As a report on the issue notes: “because urban Indian facilities are historically under-funded and do not benefit from the 100% matching rate, they face considerably greater challenges in adapting to the managed care environment (Kaiser 1997, p.5).” According to the same report, some state and local officials have sought to exclude Native Americans from Medicaid and Medicare coverage because responsibility for Native American health care was perceived as exclusively a federal responsibility (Kaiser 1997, p.10).¹⁴

Health Insurance

The average uninsured rates for American Indians and Alaska Natives for the three-year period 1999-2001 shows 27.1 percent were without coverage; this compares with 9.8 percent for non-Hispanic Whites (U.S. Census Bureau 2002). An assessment of Indians residing in IHS service areas, however, reported two-fifths (42%) of American Indians did not have health insurance of any kind and one-fifth (22%) had employer-sponsored health insurance (compared with 70% of all Americans, primarily due to extremely high unemployment rates on reservations) (RIW 2002, p.37).

Homeless Health Services

The health services issues reported above refer to the Native American population as a whole, and in some cases include those who are currently homeless. However, the extent to which Native Americans access homeless-specific services is largely unknown at the national level. We do know, however, that an estimated 7,000 Native Americans are recorded among the 550,000 homeless Americans served by the Health Care for the Homeless (HCH) grantees funded by the Bureau of Primary Health Care (BPHC) in 2002. According to the *2002-2003 HCH Grantee Profiles*, thirty-one (20%) of the (then) 154 HCH grantee organizations in 22 states across the country listed Native Americans as one of the “high user populations” they serve; only eight of these grantees also named “rural populations” as a high user population, suggesting many of these HCH grantees are serving American Indians in primarily urban locations. Among the 34 Urban Indian health programs in the United States¹⁵, none have funding expressly to provide assistance to homeless Native Americans with IHS dollars. According to Forquera, Executive Director of the Seattle Indian Health Board, “Funding guidelines often prevent urban Indian programs from successfully competing for limited homeless dollars ... All too often, local officials believe that urban Indians can use existing services for the homeless (Forquera 2002).” As a result, Indians in urban areas are referred to existing services for homeless people since their numbers are few, but no data exist on the success of follow-through on these referrals. Nonetheless, this may be a plausible explanation for why so many HCH grantees across the country indicate serving Native Americans. Regardless, HCH programs can expect to experience the repercussions of the funding constraints urban Indian programs and other IHS services are experiencing, including seeing a larger number of Native American clients as well as more dire need.¹⁶

¹⁴ Medicare is also of great importance to Indians who are elderly, especially given the very high rates of poverty they experience (see earlier discussion). However, while some sources suggest the percentage of Indian elders receiving Medicare benefits is lower than it is for the elderly in the United States as a whole, specific data were not found by the time of this publication (see , RIW 2002).

¹⁵ The first U.S. cities to receive IHS funds for direct support for Urban Indian health clinics in 1972 were Minneapolis, Minnesota; Rapid City, South Dakota; and Seattle, Washington. Currently, IHS funds 34 urban Indian health organizations at 41 sites.

¹⁶ The need is certainly dispersed among other health care providers as well, including emergency departments in hospitals. And, although they represented less than one percent of the U.S. population in 2000, Native Americans represented 2.4% of all admissions to publicly funded *substance abuse treatment programs* (DASIS 2003).

Health Care Access Issues

We asked homeless health care providers who serve Native Americans – many of them Native Americans themselves - to specify obstacles that prevent these individuals from obtaining the health care and social supports they need. Their responses are summarized in this section, and integrated with findings from published research and organizational literature. The primary access issues described here include a lack of trust in healthcare organizations; a shortage of providers; and cultural and socioeconomic factors.

Lack of Trust

As stressed in the previous section on the historical context of Native Americans, a profound lack of trust in government and other institutional programs is rooted deeply in the heritage of this population. As one HCH provider put it, “They know the treaties and what was promised.” The lack of trust in a system which has not historically offered help in a respectful manner is not limited only to non-Indian health organizations, but extends to the Indian Health Service as well. Qualitative research has documented the lack of trust between IHS and American Indians; focus groups with community members revealed perceptions of being unheard and trapped in a system over which they had no control (cited in OSG 1999, p. 4). Another report noted that a lack of confidentiality in IHS clinics keeps many from seeking tests and treatment (OWH 1996, p.6). One clinician, for example, cited numerous incidences of lax confidentiality rules in the local IHS hospital, including readily visible sign-up sheets for mental health counseling and IHS workers reporting medical findings from confidential charts to persons in the community (e.g. HIV status).¹⁷

In addition to this historically-rooted distrust of the health system generally, new research has demonstrated that provider bias may also be a contributing factor. In March 2002, the Institute of Medicine published its findings from a thorough assessment of the extent of racial and ethnic disparities in healthcare. The resulting publication, “Unequal Treatment: What Healthcare Providers Need to Know About Racial and Ethnic Disparities in Health-Care,” disputes the notion that disparities can be explained solely by structural factors. Holding access-related structural variables constant, including insurance status and the ability to pay, the Institute of Medicine found: “racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life” and, “Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare (Institute of Medicine 2002).” (Moreover, minority patient refusal of treatment does not completely explain these disparities.)

Regardless of the source, however, distrust of the healthcare system is an access barrier. One consequence of this distrust is delayed entry into the healthcare system until self-care and traditional practices have been ineffective or insufficient, during later stages of diseases. Another consequence of mistrust is non-adherence to advice given by providers.

Shortage of Providers

Another barrier to quality health care is the high turnover and shortage of health care professionals in the IHS and Urban Indian programs, particularly among nurses and nurse practitioners. The number of physicians per 100,000 population in Indian Country is 73.5 compared to the U.S. average of 229.3 (RIW 2002, p.37). Dentists are also rare; in the general population there is one dentist per 1,200 people, but in the Indian Health Service the ratio is 1 to 5,000 (Nichols, July 2002). In his remarks at the National

¹⁷ This clinician, who has a tribal enrollment number herself, chooses not to use IHS services for this reason.

Council of Urban Indian Health Fall Conference in September 2002, the Interim Director of the IHS named this a priority: “I feel we have a vacancy crisis in some health positions ...I plan to emphasize recruitment and retention of health professionals (Grimm 2002; see also RIW 2002, p.30, and OMH 2002).”¹⁸

Health care providers of Native American heritage are even more rare. A 1999 report noted that, while American Indians make up approximately one percent of the United States population, just .0003% of physicians identify themselves as American Indian (OSG 1999). The situation is also true in mental health fields: in 1996, only 29 psychiatrists in the United States were of Native American heritage (OSG 1999). This shortage is less dire among Indian Health Services, which operates under a law that applies Indian Preference in hiring and promotion practices, so the majority (69%) of the workforce are members of federally recognized tribes (RIW 2002, p.31).

The intense competition for healthcare professionals generally, much less those of Native American heritage, makes it even less likely that homeless healthcare services will be able to attract them, given that salaries are not always competitive with “mainstream” healthcare organizations. Though national statistics are not available on how many Native American healthcare professionals work specifically with homeless people, just twelve clinicians self-identified as Native American have ever been among the many hundreds of members of the national Health Care for the Homeless Clinicians’ Network since it was established in 1995.

¹⁸ Between 2002-2003, IHS actually had *decreased* funding available for training health professionals (USCCR 2003). Nationally, Native American healthcare providers have worked together to voice common concerns about Native American health and healthcare; two such examples are the Association of American Indian Physicians and the American Indian, Alaska Native and Native Hawaiian Caucus of the American Public Health Association.

Recruitment of Native American Providers¹⁹

Examples of Innovative Programs

These programs have developed components focused specifically on recruiting Native American providers; both also provide health care services for homeless individuals and families and encourage medical trainees to interact with those services.

- ▼ The Seattle Indian Health Board, an urban Indian program in Seattle, Washington (and subcontractor of the HCH program in Seattle), and the Providence Family Practice Residency Program (part of the University of Washington Medical School) have forged a partnership to create a satellite residency program to prepare physicians for careers with American Indian/Alaska Native patients. The primary goals of the program include training physicians, exposing trainees to “cultural sensitivity and appropriateness” and health issues specific to these populations, and recruiting American Indian/Alaska Native medical students. (See www.sihb.org for more information.)
 - ▼ The Southeast Alaska Regional Health Consortium (SEARHC) has responded to the need for health care professionals by establishing the “SEARHC Tribal Recruitment Project” trying to increase the number of Native youths from Southeast Alaska entering into health professions. In addition to sponsoring summer healthcare internship positions for Native college students at their medical facilities, the Project keeps a Native applicant database tracking system, offers workshops for junior high and high school age students in the communities, and provides information to high school students on programs and scholarships relevant for Native students. (See www.searhc.org for more information.)
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Cultural and Socioeconomic Factors

“Traditional cultural views ... heavily influence the ways in which Native people understand life, health, illness, and healing (OSG 1999, p.3).” Native Americans have used their own medicines, procedures and surgeries since Pre-Columbian times; traditional healers in their communities or tribes provided these treatments. In the late nineteenth century, the federal government disallowed these practices, but many of these medicines and traditions were passed through families or clandestinely by tribal healers. As noted earlier, however, Native Americans are an extremely diverse group ethnically and culturally, so it would be futile to generalize about common cultural beliefs or experiences which may serve as barriers to accessing health services. Instead, an acknowledgement that there may be aspects of specific Native American cultures or belief systems which are access barriers can be quite helpful. Following are just a few descriptions of ways in which cultural beliefs have prevented some homeless Native Americans from accessing Western medical health care.

- ÿ A Native American podiatrist in a clinic serving impoverished Native Americans commented on the practice of amputating feet due to diabetes: “When people lose their feet, they lose their self-esteem. For many Native Americans there is also a spiritual aspect. Some have told me that when they lose

¹⁹ Though not homeless-specific, the Association of American Indian Physicians has used funding from the Health Resources Services Administration (HRSA) to develop the Health Careers Opportunity Program – to increase recruitment and retention of American Indian high school and college students in the health professions. Activities include pre-admission workshops to assist with medical school applications, and site visits, mentoring and shadowing programs to provide opportunities to interact with American Indians already working as health professionals. (See www.aaip.com for more information.)

their feet, they lose their contact with Mother Earth. And some believe they can't get into afterlife because they are not whole (Nichols, July 2002)."

Ÿ Intertribal conflicts are another barrier: "[Members of the] Cheyenne [tribe] don't want to visit a Crow [tribal] hospital, or Crow a Cheyenne hospital," according to Lori Hartford, RN, HCH Program Manager of the Yellowstone City-County Health Department.

Ÿ A Navajo outreach worker for a Health Care for the Homeless clinic commented that in the Navajo tradition it is inappropriate to discuss death, so she understood the reasoning when one of her Navajo clients refused to answer the question, "Have you ever thought about dying?" during a mental health assessment.²⁰

These are just a few examples of ways in which Native American cultural beliefs have clashed with Western medicine and therefore served as barriers to individuals receiving (or trusting) healthcare. But research also warns of negative implications when ignoring cultural realities:

Ÿ "The lack of a worldview shared by both American Indian/Alaska Native patients and their providers has been associated with high treatment dropout rates for this group... The failure of addiction treatment programs, in particular, to incorporate healing elements from Native cultures, such as the medicine wheel, into their service offerings creates another barrier to seeking care. Many Natives view the use of Euro-American treatment models that focus on a single disease rather than the whole person as another form of oppression (OWH 1996, p.5; See also McCabe 2003)."

It is important to understand, however, that while cultural factors play an important role in accessing care – especially language differences – socioeconomic factors (such as poverty) may well explain more about health-seeking behaviors than cultural factors do (Waldrum 1994). This is not to belittle the importance of culture, but rather to say its effects should be understood in the context of poverty. A decade ago, one author predicted what would happen for Native persons accessing healthcare: "The future will likely see socioeconomic and class position become even more significant in explaining health care utilization, as trends toward increasing urbanization and developing bi-culturality continue... (Waldrum 1994, p. 335)." As shown previously in this report, those trends have continued, and it may in fact be the case that socioeconomic predominate in whether Native American individuals are accessing health care.

"The driving force for many of the health status and health coverage problems facing Native Americans as a whole is poverty (Kaiser 1997, p.7)."

"Addressing only health concerns cannot solve these health care problems. Improvements in the level of education and in economic prosperity are required (OMH 2002, p.3)."

Overcoming Access Barriers

When we spoke to homeless health care providers and reviewed available literature about ways to increase access for Native American clients, our findings fell into two broad categories:

1. enhance cultural awareness and knowledge; and,

²⁰ A half-Navajo woman who grew up on a reservation wrote her memoirs about her experiences in medical school on her way to becoming a surgeon. When she dissected her first cadaver, she broke this important rule from her culture ("Navajos do not touch the dead. Ever.") Her book describes other examples of ways in which her medical training forced her to ignore valuable healing practices (Arviso 2000).

2. improve communication and coordination of services with IHS and other Native-specific services

Enhancing Cultural Awareness and Knowledge

A distinction is made in this section between “culturally appropriate care” which can only be offered within the proper cultural context by members of the same culture, and “culturally sensitive care” which can be offered by non-culture members (see Waldram 1994 for discussion). Both approaches were recommended during our interviews: the former by recruiting Native American staff and/or conjoining Western and Native medicine; the latter, by providing cultural education or training.

Recruit Native American Staff

Several HCH clinics have found it helpful to recruit staff with Native American backgrounds, including intake and clinical personnel. Advertising for open positions in Native American organizations and agencies in the community can be helpful in the recruitment process. Those who have successfully hired Native American staff have found their presence to be helpful in creating an atmosphere more welcoming to Native American clients; their cultural background and understanding is often more important than language skills, though this depends on the population served. It will not necessarily result in large numbers of Native Americans visiting the clinics, however: the Albuquerque HCH has found coordinating outreach with a local Native American organization enables them to make better contacts while on outreach, though it is “a bigger bridge to get them from the street to the clinic (Matias Vega).”

A few of the Native-run organizations, in addition to ensuring that Native Americans comprise a certain proportion of their Boards and/or staff, hire staff specifically to assist their Native American clients in obtaining tribal documentation. For example, the Hunter Health Clinic in Wichita, Kansas (funded as an Urban Indian clinic and as an HCH project), has a Native American Registrar on staff, and the Salt Lake Indian Walk-In Clinic has a “family preservation specialist.”

Enhance Cultural Sensitivity

While research is not conclusive on the impact of matching providers and patients on the basis of race, it is generally understood that treatment effectiveness is enhanced when the provider is culturally knowledgeable. Several of the health professionals we spoke with agreed: comments included, “There are things you just can’t learn” and “It’s important to have input from a Native American person.” All thought that at least some attempt should be made to enhance cultural understanding, as seen in the following comments:

“Native Americans don’t want physicians to speak in a clinical language. They want primary care providers to ‘speak my truth,’ that is, speak plainly...(Norman Riddle, White Bird Clinic, Eugene, Oregon).”

“What I have found useful is reading as much as possible about the Native American experience, becoming sympathetic to [their] experience and worldview, cultivating friendships with Native people, participating in cultural events and especially understanding the peoples’ perspective of health and the role of the health care worker (Heather Barr, Seattle, Washington).”

“All people who work with Native Americans who are homeless need to learn something about the culture (Carol Marshall, Rapid City Community Health Care, Rapid City, South Dakota).”

One Native American clinician who provides cultural sensitivity training to her fellow staff suggests understanding certain traditions can be very helpful in making communication more effective. For example, acknowledging that their Native American client may take more time to respond after a question is asked, and knowing that avoiding direct eye contact is a sign of respect.

Conjoin Native and Western Medicine

One way to increase cultural appropriateness or competence is through increasing the availability of physicians who conjoin traditional Native and Western medicine in their practices. Melding traditional healing and Western medicine has become increasingly recognized for its effectiveness, particularly in mental health professions (See Lamberg 2000, Mehl-Madrona 2003, Aviso-Arvalo 2000, Cohen 2003, and Rodenhauer 1994). In March 2002, the Association of American Indian Physicians (AAIP) unanimously passed a resolution that supported the “respectful collaboration” between Western-trained physicians and American Indian and Alaska Native traditional healers. The resolution acknowledges that many Native Americans on and off reservations use traditional systems of health care alone or in combination with western medicine. Such traditional practices restore clients’ “balance of mind, body and spirit.”

Lewis Mehl-Madrona is one advocate for using alternative therapies and traditional Native American healing practices when caring for homeless individuals. Some of the fundamental elements of healing he recommended during a presentation to the Health Care for the Homeless Clinicians’ Network include: “storytelling, spirituality, valuing the role of time in healing, active patient involvement in self-care, building relationships through individual and group therapy, and involvement with community through ceremony (HCH Clinicians’ Network 1999, p.2; see Mehl-Madrona 2003 for further discussion).” The Hunter Health Clinic HCH in Wichita, Kansas, has had some success with a Native version of the 12-step program for those needing substance use treatment; this program incorporates features such as talking circles, eagle feathers, and smudging (burning of sage) (see Appendix for more information).

Collaborations with Native American Organizations

Another set of solutions to access barriers recommended by interviewees centers on collaborations between homeless and mainstream health care providers, including the Indian Health Service. Many of those programs which see a large number of American Indian patients said they would like to improve collaborations with IHS-based programs in their communities to help their clients access those services for which they might be eligible. (“We don’t turn anyone away just because they’re eligible to receive IHS services, but...we act as a bridge to IHS.”) Given the migratory movement of many of their homeless clients, understanding how IHS eligibility rules and services operate on reservations and in urban Indian clinics is critical for Health Care for the Homeless and other clinics to enable them to advocate on behalf of their clients.

For clients who are not eligible for IHS, however, other Health Care for the Homeless clinics are working on collaborating with Native-run programs in their communities. For example, the San Francisco-based Native American Health Center subcontracts with two HCH programs in the area; an Indian Walk-In program in Salt Lake City, Utah, is a referral source for that local HCH; and the Albuquerque HCH coordinates outreach efforts with the First Nations Community Healthsource, an Urban Indian health center. Interviewees commented that these collaborations can be extremely helpful in ensuring that Native American clients are receiving culturally appropriate and competent services.

Native-Specific Health Programs Serving Homeless Populations

Examples of Innovative Programs and Approaches

Alaska: The Southeast Alaska Regional Health Consortium (SEARHC), based in Juneau, Alaska, is a nonprofit tribal health care delivery consortium serving 18 Native communities in southeast Alaska – a 600-mile panhandle. SEARHC is funded through an IHS Compact, state and federal and private grants and other revenue sources. In 2002, it received a grant to provide HCH medical, dental, and social services to the homeless population in Juneau. SEARHC is one of the largest and oldest Native-run health organizations in the country, and as such strives to incorporate traditional Native cultural practices and values where possible. For example:

- *Board representatives* are selected by the tribal governing body in each community;
- the Raven’s Way residential substance abuse treatment center for youth includes *adventure-based therapy and Native American cultural activities*; and,
- the “*Wisewoman*” program focuses on cardiovascular health for women age 40-64, providing cardiovascular screening, lifestyle counseling, and various nutrition, physical activity and tobacco cessation interventions in five communities. Examples of physical activity events include the “Ravens vs. Eagles” - an intertribal physical activity contest during which each 30 minutes of physical activity earns participants one point - the losing clan hosts a potlatch for the winning clan.

Kansas: Hunter Health Clinic in Wichita, Kansas was incorporated as The Wichita Urban Indian Health Center, Inc. from 1980 to 1985; in September 1985, the clinic expanded to a Community Health Center and changed its name to The Hunter Health Clinic, Inc. A quote from Sitting Bull predominates on their website: “Let us put our minds together and see what life we will make for our children.”

- *Native American representation:* Native Americans comprise a minimum of 51% of the Board of Trustees and of service users.
- A *Native American Registrar* assists clients in answering questions about eligibility for health care services; she also helps them obtain documentation for proof of tribal descent (e.g. tribal enrollment card, Certificate of Degree of Indian Blood, etc.).
- All staff are required to participate in *cultural sensitivity training* upon hire and annually thereafter; the training is provided by two of the Hunter Health Clinic’s Native American staff.

Utah: The Salt Lake City Indian Walk-In has held a contract with Indian Health Services for 27 years to provide a needs assessment of Native American health care and give client referrals to Community Health Centers. In the last decade, such emergency assistance services as a food bank and financial help with utilities and rent payments have been added to the intake program. Native Americans of recognized tribes who have full access to Indian Health Services, as well as members of non-recognized tribes and American Indians who do not meet the “blood quantum” standard for tribal membership, are regular visitors.

- *Native American staff:* The 18-member staff includes 15 health care workers of Native American heritage, who facilitate about 30 client visits monthly, although the number varies seasonally. When warranted, the staff helps eligible Native Americans apply for government entitlements.
 - Plans have been developed for the *Indian Walk-in Clinic* to expand its services to a “one-stop shop” facility that includes diabetes, substance abuse and smoking cessation treatment programs, regular physical and dental examinations, mental health evaluations and treatments, and obstetrics programs.
 - A building has been purchased within one-half block of the present site that will also house a *cultural museum and library*, a business incubation program, and a health education program that includes *access to traditional healers*. A “*family preservation specialist*” will be added to the staff, as well as youth outreach workers.
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Native-Specific Health Programs Serving Homeless Populations
Examples of Innovative Programs and Approaches
CONTINUED

Minnesota: With funding from the Stewart B. McKinney Homeless Assistant Act initiative, an American Indian Task Force on Housing and Homelessness was formed in the Twin Cities (St. Paul and Minneapolis, Minnesota) in 1991. Task Force members, concerned about the scope of homelessness among Native people (10% at that time) developed an American Indian Housing and Community Development Corporation (AIHCDC) in 1992. The AIHCDC operates several programs designed to provide a better level of support for American Indians in the community living on the streets or in shelters. Examples of available programs include:

- a *Chemical Health Services* program (a detox service started in 2002);
- the *KOLA program*, a street outreach service that provides culturally-specific supportive services to chronically inebriated and homeless Native Americans (started in 1999); and
- *On Track*, a program designed to support clients serious about sobriety using skill building activities (computers, beadwork, writing, drawing and painting).

Other services performed by AIHCDC include housing advocacy, tenant training and certification, and neighborhood revitalization.

Note: Contact information and website addresses can be found for these and other organizations in the Appendix of this report.

CONCLUSIONS

It is clear that the vast demographic variation within and among Native Americans who are homeless, the challenges in accessing diverse healthcare services and systems, tribal politics and policies, and the distribution of Native Americans across geographic regions of the country prohibit sweeping conclusions about homelessness among Native Americans. Nevertheless, it is equally clear that Native Americans are at extremely high risk for homelessness, are experiencing much greater health disparities than other groups in the U.S. population, and will increasingly have difficulty accessing healthcare services through the Indian Health Service while budget cuts continue and Indians migrate into metropolitan areas. The latter is only exacerbated by a profound lack of trust this population has in government-run organizations. It is therefore increasingly important to enhance awareness, understanding, and sensitivity toward the issues raised in this paper, and to make every effort to collaborate with IHS services and other Native-run organizations who are best equipped to provide culturally competent healthcare. While the barriers are immense, the fact that Native Americans on the whole have profound strengths within their communities and extended families should not be overlooked; to the extent possible, those strengths should be tapped as important coping strategies.

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APPENDIX

NATIVE AMERICAN ORGANIZATIONS AND WEBSITES

NATIONAL ORGANIZATIONS/WEBSITES

The national newspaper **Indian Country** is the “Nation’s Leading American Indian News Source” and often includes articles on Indian health policy issues. www.indiancountry.com

Indian Health Service www.ihs.gov Go to the Press and Public Information page to download publications, including the IHS Provider, published monthly by the IHS Clinical Support Center. This publication includes information targeted for health care professionals who provide health care services to American Indians and Alaska Natives.

Association of American Indian Physicians, Inc. www.aaip.com

- For the AAIP Traditional Indian Medicine website: www.aaip.com/tradmed/index.html
- For information about Cross-Cultural Medicine Workshops, see www.aaip.com/tradmed/medicineworks.html

Native American-specific **Medicare/Medicaid** information: www.hcfa.gov/Medicaid/aian

National American Indian Housing Council – the only Native American non-profit organization “devoted exclusively to Indian housing” – its homepage can be found at www.naihc.net.

National Council of Urban Indian Health www.ncuih.org This national membership organization was founded in 1998 to meet unique health care needs of urban Indians through education, training, and advocacy. Its long-term vision is to serve as a resource center for Indian healthcare providers, providing training and resources through regional offices.

National Resource Centers for Older Indians - Since 1994, the Administration on Aging has provided grants to two universities to establish national resource centers for older Indians – these Centers provide culturally appropriate health care, community-based long-term care, and related services. For more information see their websites, listed below:

- Native Elder Health Care Resource Center at the University of Colorado: www.uchsc.edu/ai/nehcrc
- National Resource Center on Native American Aging at the University of North Dakota www.med.und.nodak.edu/depts/rural//nrnaa

The **Native American Indian General Service Office** has worked to incorporate Native American traditions and customs into Alcoholics Anonymous meeting structures and protocols in attempt to attract alcoholic Native Americans to benefit from this form of substance abuse treatment more effectively www.naigso-aa.org

U.S. Department of Housing and Urban Development (HUD) **Office of Native American Programs** (ONAP). See this website on information about grant programs for combating environmentally-related healthcare issues and funds for community healthcare facilities. www.hud.gov/offices/pih/ih/onap Their website asserts that “ONAP ensures that safe, decent and affordable housing is available to Native American families, creates economic opportunities for Tribes and Indian housing residents, assists Tribes in the formulation of plans and strategies for community development, and assures fiscal integrity in the operation of the programs. “

Urban Indian Health Institute www.uihi.org A division within the Seattle Indian Health Board, this organization was established in 2000 to provide national centralized management of health surveillance, research and policy considerations on health issues affecting urban American Indians and Alaska Natives.

STATE AND REGIONAL ORGANIZATIONS/WEBSITES

Alaska

SouthEast Alaska Regional Health Consortium
3245 Hospital Drive
Juneau, AK 99801
Phone: 907-463-4000
www.searhc.org

www.whitebirdclinic.org

Washington

Seattle Indian Health Board
606 - 12th Avenue South
Seattle, WA 98144-2008
Phone: 206-324-9360
www.sihb.org

California

Native American Health Center
3124 International Blvd
Oakland, CA 94601
Phone: 510-535-4460
www.nativehealth.org

Kansas

Hunter Health Clinic, Inc.
2318 East Central
Wichita, KS 67214
Phone: 316-262-5125
www.hunterhealthclinic.org

Minnesota

American Indian Policy Center
St. Paul, Minnesota
651-644-1728
www.airpi.org

American Indian Housing and Community
Development Corporation (AIH CDC)
Minneapolis, Minnesota
Phone: 612-813-1610
www.americanindianhousing.org

Montana

Yellowstone City-County Health Department
HealthCare for the Homeless Program
123 South 27th Street
Billings, Montana
Phone: 406-247-3200
www.ycchd.org

Oregon

White Bird Clinic
341 East 12th Avenue
Eugene, Oregon 97401
Phone: 541-342-8255
Toll-Free: 800-422-7558